WISER CHOICE
MILWAUKEE COUNTY

SERVICE ACCESS TO INDEPENDENT LIVING &
ALCOHOL AND OTHER DRUG ADDICTION UNITS
of the
BEHAVIORAL HEALTH DIVISION OF MILWAUKEE COUNTY

Treatment Verification Form

Client Name: ____

Treatment Provider: ____

Type: **Group** or **Individual** (please circle) Date: ______________ Time: ______________

Counselor (Please Print): ______________________________ Counselor Telephone: ____________

Counselor Signature: ____

Treatment Provider: ____

Type: **Group** or **Individual** (please circle) Date: ______________ Time: ______________

Counselor (Please Print): ______________________________ Counselor Telephone: ____________

Counselor Signature: ____

Treatment Provider: ____

Type: **Group** or **Individual** (please circle) Date: ______________ Time: ______________

Counselor (Please Print): ______________________________ Counselor Telephone: ____________

Counselor Signature: ____

Treatment Provider: ____

Type: **Group** or **Individual** (please circle) Date: ______________ Time: ______________

Counselor (Please Print): ______________________________ Counselor Telephone: ____________

Counselor Signature: ____

Treatment Provider: ____

Type: **Group** or **Individual** (please circle) Date: ______________ Time: ______________

Counselor (Please Print): ______________________________ Counselor Telephone: ____________

Counselor Signature: ____

***Please bring this form weekly to your Recovery Support Coordinator to pick up a bus pass for the next week.**